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IL-28B (IFN-λ3) and IFN-α synergistically inhibit HCV replication

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SUMMARY. Genetic variation in the IL-28B (interleukin-28B; interferon lambda 3) region has been associated with sustained virological response (SVR) rates in patients with chronic hepatitis C treated with peginterferon-α and ribavirin. However, the mechanisms by which polymorphisms in the IL-28B gene region affect host antiviral responses are not well understood. Using the HCV 1b and 2a replicon system, we compared the effects of IFN-λs and IFN-α on HCV RNA replication. The anti-HCV effect of IFN-λ3 and IFN-α in combination was also assessed. Changes in gene expression induced by IFN-λ3 and IFN-α were compared using cDNA microarray analysis. IFN-λs at concentrations of 1 ng/mL or more exhibited concentration- and time-dependent HCV inhibition. In combination, IFN-λ3 and IFN-α had a synergistic anti-HCV effect; however, no synergistic enhancement was observed for interferon-stimulated response element (ISRE) activity or upregulation of interferon-stimulated genes (ISGs). With respect to the time course of ISG upregulation, the peak of IFN-λ3-induced gene expression occurred later and lasted longer than that induced by IFN-α. In addition, although the genes upregulated by IFN-α and IFN-λ3 were similar to microarray analysis, interferon-stimulated gene expression appeared early and was prolonged by combined administration of these two IFNs. In conclusion, IFN-α and IFN-λ3 in combination showed synergistic anti-HCV activity *in vitro*. Differences in time-dependent upregulation of these genes might contribute to the synergistic antiviral activity.

Keywords: HCV, IFN-λ, IL-28B, ISG, synergistic inhibition, microarray.

INTRODUCTION

In 2009, reports from three genome-wide association studies revealed that several single-nucleotide polymorphisms (SNPs) (rs12979860, rs12980275 and rs8099917) around the IL-28B (interleukin-28B; interferon lambda 3) gene are strongly associated with sustained viral response (SVR) to PEG-IFN and RBV treatment for chronic hepatitis C [1–3]. Specifically, patients with the TG or GG genotype at rs8099917 infected with genotype 1b are more resistant to PEG-IFN and RBV treatment than patients with the TT genotype. IL-28B haplotypes were also reported to be strongly associated with spontaneous HCV clearance [1, 4, 5].

IL-28B is a member of the type III IFN family [6], consisting of IFN-λ1 (IL-29), IFN-λ2 (IL-28A) and IFN-λ3 (IL-28B). IFN-λs bind to their cognate receptor, composed of IL28R1 and IL10R2, and then activate the receptor-associated Janus-activated kinases (Jak) 1 and tyrosine kinase (Tyk) 2, leading to the activation of downstream signal transducer and activator of transcription (STAT) proteins, STAT1 and STAT2. Similar to type I IFN signalling, the Jak-STAT signalling pathway activates the IFN-stimulated response element (ISRE) within the promoter region of interferon-stimulated genes (ISGs) [7].

Concerning the functional role of IL-28B in HCV infection, two of *in vivo* studies assessed the correlation of IL-28A/B mRNA levels in whole blood and peripheral blood mononuclear cells (PBMC) with IL-28B haplotypes at position rs8099917. IL-28A mRNA and IL-28B mRNA levels in subjects with the TT genotype were higher than in subjects with other genotypes (TG or GG), suggesting an association between higher amounts of endogenous IFN-λs and HCV clearance [2, 3]. On the other hand, subjects

Abbreviations: DMEM, Dulbecco's modified Eagle's medium; FBS, foetal bovine serum; ISG, interferon-stimulated genes; MTS, dimethylthiazol carboxymethoxyphenyl sulphophenyl tetrazolium; PBMC, peripheral blood mononuclear cells; SNP, single-nucleotide polymorphisms; STAT, signal transducer and activator of transcription; SVR, sustained viral response.

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with the TT genotype at SNP rs8099917 were reported to have lower expression levels of ISGs in the liver during the pretreatment period as compared with subjects with the TG or GG genotypes [8]. Several *in vitro* studies support a direct role of IFN-λs in the control of HCV replication through the innate immune pathway. In a cell culture system, Marcello *et al.* [9] showed that IFN-λ1 inhibited HCV replication with similar kinetics to that of IFN-α, although IFN-λ1 induced stronger upregulation of ISGs and this effect lasted longer. Moreover, combinations of IFN-λ1 and IFN-α had a greater inhibitory effect on HCV replication compared with the individual agents [10].

As suggested by the studies performed to date, a change in IFN-λ3 expression might be a key mechanism by which IL-28B SNPs determine the response to PEG-IFN and RBV. Considering that IFN-λ1 plays a direct role in the control of HCV replication and that IFN-λ1 enhances the antiviral activity of IFN-α, it seems reasonable to speculate that IFN-λ3 plays a similar antiviral role. Therefore, in this study, we investigated the direct antiviral role of IFN-λ3 alone and in combination with IFN-α using an HCV replicon system. In addition, we used microarray analysis to investigate the influence of IFN-λ3, alone or in combination with IFN-α, on the regulation of ISG-mediated antiviral pathways.

MATERIALS AND METHODS

Cell culture and HCV replicon

The human hepatoma cell lines OR6 and Huh7.5.1 were maintained in Dulbecco's modified Eagle's medium (DMEM: Sigma, St. Louis, MO, USA) supplemented with 10% foetal bovine serum (FBS) at 37°C in 5% CO_2. JFH-1-infected Huh7.5.1 cells were grown in DMEM supplemented with 10% FBS. The OR6 cell line, harbouring full-length genotype 1b HCV RNA and co-expressing *Renilla* luciferase (ORN/C-5B/KE) [11], was established in the presence of 500 μg/mL G418 (Promega, Madison, WI, USA).

Reagents

IL-28A (IFN-λ2), IL-28B (IFN-λ3) and IL-29 (IFN-λ1) were obtained from R&D Systems (Minneapolis, MN, USA). IL-28A and IL-29 are recombinant proteins generated from an NSO-derived murine myeloma cell line, and IL-28B is a recombinant protein generated from the CHO cell line. Interferon alpha-2b (INTRON®A 300 IU) was obtained from Schering-Plough Corporation (Kenilworth, NJ, USA).

Reporter plasmids and luciferase assay

HCV replication in OR6 replicon cells was determined by monitoring *Renilla* luciferase activity (Promega). To monitor IFN signalling directed by the interferon-stimulated response element (ISRE), the plasmids pISRE-luc expressing firefly luciferase were cotransfected using FuGENE®6 Transfection Reagent (Roche, Indianapolis, IN, USA) following the manufacturer's protocol. Luciferase activity was quantified using the dual-luciferase assay system (Promega) and a GloMax 96 Microplate Luminometer (Promega). Assays were performed in triplicate, and the results were expressed as mean ± SD percentage of the control values.

Quantification of HCV core protein and RNA

We quantified HCV core protein in culture supernatant using Lumipulse Ortho HCV Ag (Ortho Clinical Diagnostics, Tokyo, Japan) as specified by the manufacturer. The principle of the measurement method is based on the chemiluminescent enzyme immunoassay (CLEIA) [12].

Real-time reverse transcription polymerase chain reaction (RT-PCR)

Intracellular genomic JFH-1 HCV RNA as well as cellular mRNA of IFI-6, IFIT1 (ISG56), DDX60, OAS2, Mx1 and USP18 was quantified by TaqMan RT-PCR. The cells were lysed and subjected to reverse transcription without purification of RNA using a Cells-to-Ct kit (Applied Biosystems, Foster City, CA, USA) according to the manufacturer's protocol. Quantitative PCR was performed in triplicate using a 7500 Real-Time PCR System (Applied Biosystems) and TaqMan Gene Expression Assays (Applied Biosystems) according to the manufacturer's instructions. The sequences of the sense and antisense primers and the TaqMan probe for 5'UTR region of HCV were 5'-TGCGG AACCGGTGAGTACA-3', 5'-CTTAAGGTTTAGGATTCGTGCT CAT-3' and 5'-(FAM)CACCCTATCAGGCAGTACCACAAGG CC(TAMRA)-3', respectively. TaqMan probes for IFI-6, IFIT1 (ISG56), DDX60, OAS2, Mx1 and USP18 were purchased from Applied Biosystems. Primers for 18s rRNA (Applied Biosystems) were used as internal control.

Microarray analysis

OR6 replicon cells were harvested by centrifugation after exposure to 0.01 ng/mL IFN-α, 10 ng/mL IFN-λ3 or a combination of both for 6, 12, 24 and 48 h. Total RNA was isolated from cells using the RNeasy Mini Kit (Qiagen, Valencia, CA, USA). On-column DNase digestion was performed using the RNase-Free DNase Set (Qiagen). Quality control of extracted RNA was performed with the 2100 Bioanalyzer (Agilent Technologies, Palo Alto, CA, USA).

The RNA was then amplified and labelled using the Ambion® WT Expression Kit and GeneChip® WT Terminal Labelling and Control Kit (Affymetrix, Santa Clara, CA, USA). cDNA was synthesized, labelled and hybridized to the GeneChip® array according to the manufacturer's protocol, starting with 200-ng total RNA. The GeneChips were finally washed

and stained using the GeneChip® Fluidics Station 450 (Affymetrix) and then scanned with the GeneChip® Scanner 3000 7G (Affymetrix).

Affymetrix CEL files were imported into GeneSpring GX v.11.5 (Agilent Technologies, Santa Clara, CA, USA) analysis software. Data were normalized using robust multichip average analysis (RMA).

Dimethylthiazol carboxymethoxyphenyl sulphophenyl tetrazolium (MTS) assays

To evaluate the cell viability, dimethylthiazol carboxymethoxyphenyl sulphophenyl tetrazolium (MTS) assays were performed using a CellTiter 96 AQueous One Solution Cell Proliferation Assay kit (Promega) according to the manufacturer's instructions.

Statistical analyses

Statistical analyses were performed using an unpaired, two-tailed Student's *t*-test. *P* values of < 0.05 were considered to be statistically significant.

RESULTS

IFN-λ1, IFN-λ2 and IFN-λ3 demonstrate antiviral activity against HCV

To determine the antiviral effect of IL-29 (IFN-λ1), IL-28A (IFN-λ2) and IL-28B (IFN-λ3) against HCV, OR6/ORN/C-5B/KE cells were seeded in 96-well plates for 24 h and then treated with IFN-λ1, IFN-λ2, IFN-λ3 or IFN-α at various concentrations for another 24, 48 and 72 h. In this system, the *Renilla* luciferase activity reflects the amount of HCV RNA synthesized. As shown in Fig. 1, at concentrations of 1 ng/mL or more, all IFN-λs led to a concentration- and time-dependent decrease in luciferase activity of the OR6/C-5B replicon. IFN-λ3 at 10 ng/mL inhibited HCV replication (32% reduction, $P < 0.05$) to a similar extent as 0.01 ng/mL IFN-α (49% reduction, $P < 0.05$) by 48 h.

We also assessed the effects of IFN-λ1, IFN-λ2 and IFN-λ3 on Huh7.5.1/JFH-1 cells. JFH-1 cells were seeded in 96-well plates for 24 h and then treated with IFN-λ1, IFN-λ2, IFN-λ3 or IFN-α at various doses for another 48 h. To determine their antiviral effect, HCV core protein in the medium and intracellular HCV RNA were measured by CLEIA and quantitative real-time RT-PCR, respectively. HCV RNA quantitative PCR assays were multiplexed for 18s ribosomal RNA to control for the amount of input RNA. As shown in Fig. 2, all IFN-λs inhibited HCV replication in JFH-1 cells in a concentration-dependent manner. Similarly, all of the IFN-λs caused suppression of HCV core protein secretion into the cell culture medium (Figure S1).

In C-5B system, there was no evident cytotoxicity below 100 ng/mL in any interferons except for IFN-λ1 (Figure S2). On the other hand, cytotoxicity was observed in lesser concentrations by those IFNs in JFH-1 system. However, as demonstrated in Fig. 2 and Figure S3, antiviral effect exceeded the cytotoxicity in the JFH-1 system.

Synergistic inhibition of HCV replication by IFN-λ3 and IFN-α in combination

We examined whether the combination of IFN-λ3 and IFN-α induces greater antiviral activity as compared with the individual cytokines alone. OR6/ORN/C-5B/KE cells were treated with the combinations of IFN-λ3 and IFN-α at various concentrations for 48 h. As shown in Fig. 3a, the relative concentration–inhibition curves of IFN-α were plotted for each fixed concentration of IFN-λ3, and the curves shifted to the left with increasing concentrations of IFN-λ3. The results indicate a synergistic effect of IFN-λ3 and IFN-α against HCV replication. We confirmed the synergistic effect of IFN-λ3 and IFN-α by isobologram (Fig. 3b). The inhibitory effects of the combination were quantified according to the method of Chou *et al.* using the CalcuSyn software program (Biosoft, Cambridge, UK). At the ED_{50} of each drug, the combination index was 0.40-0.61, indicating significant synergism. We also assessed the effect of the combination on Huh7.5/JFH-1 cells by HCV RNA quantitative PCR assays and HCV core protein secretion. At the ED_{50} of each drug, the combination index was 0.55 and 0.48, respectively (Table S1). The cytotoxicity was not observed at the range of concentration tested (Fig. S2E, S3E).

IFN-λ3 induces ISRE promoter activity

We used the ISRE luciferase reporter assay to assess activity downstream of the JAK-STAT signalling pathway. The ISRE-firefly luciferase plasmid was transfected into OR6/ORN/C-5B/KE cells for 24 h, and these cells were cultured with various concentrations of IFN-λ3 and IFN-α for another 12, 24 or 48 h. Firefly and *Renilla* luciferase activity was then measured.

IFN-λ3 induced ISRE luciferase activity in a time-dependent manner: activity was elevated threefold after treatment with 100 ng/mL IFN-λ3 for 48 h (Fig. 4). In contrast, IFN-α induced ISRE luciferase more rapidly, producing maximal activation of the response to IFN-α at 12 h. The combination of IFN-λ3 and IFN-α induced ISRE luciferase activity similarly to IFN-λ3 alone.

IFN-α and IFN-λ3 induce expression of similar genes in HCV 1b replicon cells

OR6/ORN/C-5B/KE cells were stimulated for 6, 12, 24 and 48 h with 0.01 ng/mL IFN-α, 10 ng/mL IFN-λ3 or a combination of both, while controls were left unstimulated for the same time interval. Induction of gene expression by IFNs was analysed in microarray experiments.

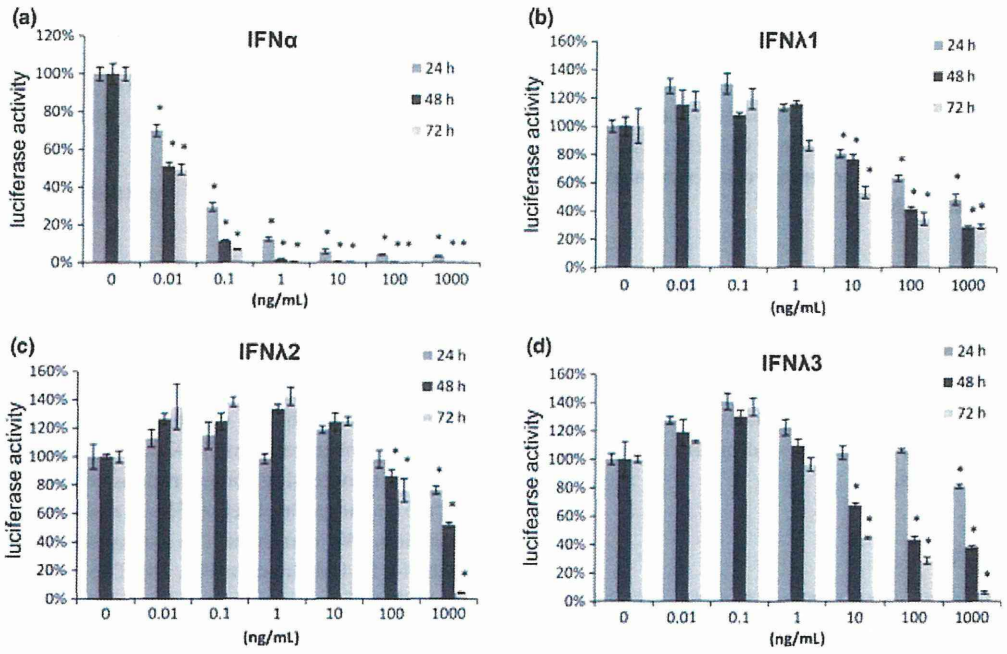

Fig. 1 IFN-α and IFN-λs inhibit HCV replicon in OR6 cells. Specific inhibition of the replication of a full-length HCV genotype 1b replicon by (a) IFN-α and (b) IFN-λ1, (c) IFN-λ2, (d) IFN-λ3 were quantified on the basis of luciferase activity. Symbols show the mean value of triplicate wells; error bars show the SD. *: $P < 0.05$ *vs* control (IFN 0 ng/mL) of each time point.

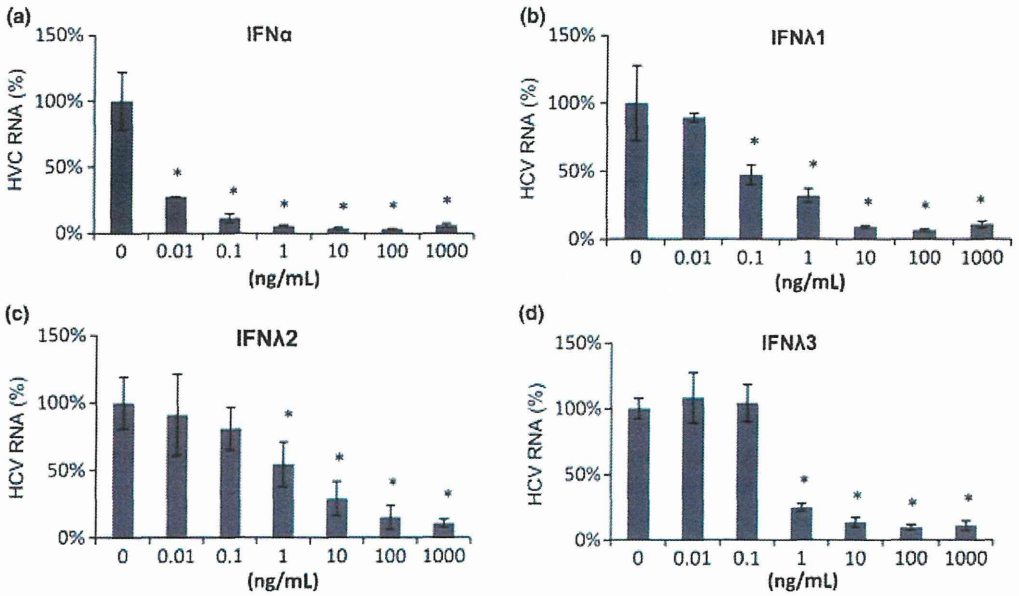

Fig. 2 IFN-α and IFN-λs inhibit HCV replicon in Huh7.5.1 cells. JFH1-infected Huh7.5.1 cells were incubated with various concentrations of (a) IFN-α and (b) IFN-λ1, (c) IFN-λ2, (d) IFN-λ3. After 48 h of treatment, total RNA was isolated and reverse transcribed, after which quantitative PCR was performed. Symbols show the mean value of triplicate wells; error bars show the SD. *: $P < 0.05$ *vs* control (IFN 0 ng/mL).

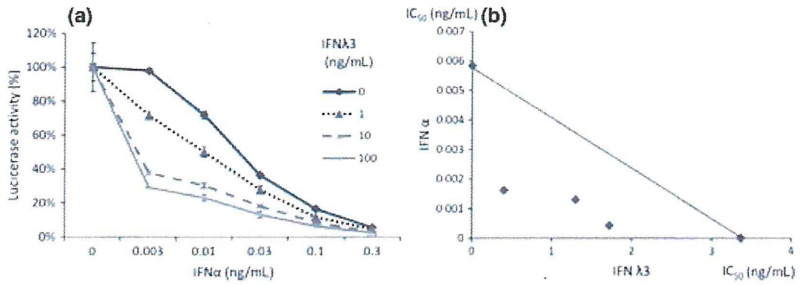

Fig. 3 Synergistic inhibitory effect of IFN-λ3 with IFN-α on hepatitis C virus replication. OR6/ORN/C-5B/KE cells were treated with combinations of IFN-λ3 with IFN-α at various concentrations. (a) The relative concentration–inhibition curves of IFN-α plotted for each fixed concentration of IFN-λ3 (0, 1, 10 and 100 ng/mL). (b) Classic isobologram for IC_{50} of IFN-λ3 with IFN-α in combination.

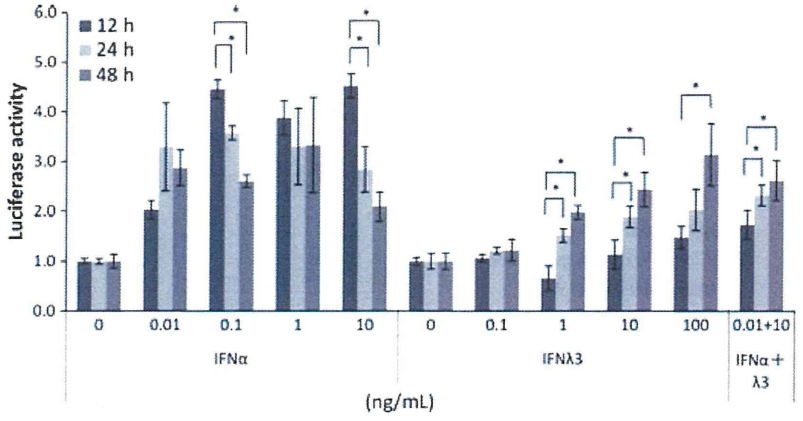

Fig. 4 IFN-stimulated response element (ISRE) promoter activity induced by IFN-α, IFN-λ3 or combination of IFN-α and IFN-λ3. OR6/ORN/C-5B/KE cells transfected with ISRE-firefly luciferase were cultured with various concentrations of IFN-α alone, IFN-λ3 alone or 0.01 ng/mL IFN-α plus 10 ng/mL IFN-λ3. ISRE-firefly luciferase activity at 24 h after transfection. Symbols show the mean value of triplicate wells; error bars show the SD. *: $P < 0.05$.

At all time points, the IFN-λ3-treated samples showed a tendency for the induction of a larger number of genes than samples treated with IFN-α. However, as shown in Table 1 listing the top 25 genes that were upregulated by both IFN-α and IFN-λ3 at 12 h, most of the upregulated genes are previously identified ISGs and the genes with high ranks were similar irrespective of the type of IFN or time point.

The time course of ISGs regulation differs between IFN-α and IFN-λ3

By microarray analysis, ISGs were more rapidly induced after the addition of IFN-α *vs* IFN-λ3 (data not shown). To confirm the rapid induction of ISGs by IFN-α, six ISGs, that is, IFI-6, IFIT1 (ISG56), DDX60, OAS2, Mx1 and USP18, were quantified for time-dependent expressional change by real-time RT-PCR. Expression of most of the genes upregulated by IFN-α peaked at 12 h and fell thereafter. In contrast, expression of IFN-λ3-induced genes peaked at 24 h and lasted up to 48 h. Combination of IFN-α and IFN-λ3 induced ISG with peak effects occurring at 12–24 h and lasting up to 48 h (Fig. 5).

DISCUSSION

In this study, we demonstrated that IFN-λ family members have distinctive time-dependent antiviral activities in an HCV replicon system and that IFN-λ3 and IFN-α have a synergistic effect in combination. Moreover, we attempted to identify the antiviral mechanism of IFN-λ3 by conducting a cDNA microarray analysis.

In previous studies, anti-HCV activity of IFN-λ1, IFN-λ2 and IFN-λ3 was reported in JFH-1 and OR6/C-5B systems [13]. Time-dependent anti-HCV activity has also been observed with IFN-λ1 [9]. In this study, we confirmed the previous results and added the further finding that time-dependent antiviral activity is not limited to IFN-λ1, but rather is common among all IFN-λs.

Table 1 Top 25 genes that were upregulated by both IFN-α and IFN-λ3 at 12 h

Gene bank ID	Gene symbol	Gene description	IFN-α 0.01 ng/mL fold increase	IFN-λ3 10 ng/mL fold increase	IFN-α+IFN-λ3 fold increase
BC007091	IFIT1	Interferon-induced protein with tetratricopeptide repeats 1	4.01	4.49	4.87
BC049215	OAS2	2′-5′-oligoadenylate synthetase 2, 69/71kDa	3.06	3.88	4.48
M33882	MX1	Myxovirus (influenza virus) resistance 1	3.24	3.29	3.69
AF095844	IFIH1	Interferon induced with helicase C domain 1	2.73	3.02	3.54
BC038115	DDX60	DEAD (Asp-Glu-Ala-Asp) box polypeptide 60	2.70	2.92	3.51
BC011601	IFI6	Interferon, alpha-inducible protein 6	3.07	3.24	3.42
BC042047	HERC6	Hect domain and RLD 6	2.56	2.75	3.34
AF442151	RSAD2	Radical S-adenosyl methionine domain containing 2	1.32	2.59	3.28
U34605	IFIT5	Interferon-induced protein with tetratricopeptide repeats 5	2.47	2.91	3.25
AY730627	OAS1	2′,5′-oligoadenylate synthetase 1, 40/46kDa	2.32	2.57	3.05
AB006746	PLSCR1	Phospholipid scramblase 1	2.37	2.51	3.03
AF307338	PARP9	Poly (ADP-ribose) polymerase family, member 9	2.39	2.46	2.94
M87503	IRF9	Interferon regulatory factor 9	2.61	2.59	2.85
AK297137	IFIT3	Interferon-induced protein with tetratricopeptide repeats 3	1.90	2.36	2.79
AK290655	EIF2AK2	Eukaryotic translation initiation factor 2-alpha kinase 2	2.47	2.45	2.77
BX648758	PARP14	Poly (ADP-ribose) polymerase family, member 14	2.07	2.25	2.66
BC132786	DDX58	DEAD (Asp-Glu-Ala-Asp) box polypeptide 58	1.83	2.17	2.59
AF445355	SAMD9	Sterile alpha motif domain containing 9	2.07	2.08	2.56
	DDX60L	DEAD (Asp-Glu-Ala-Asp) box polypeptide 60-like	1.63	1.92	2.39
BC014896	USP18[1] USP41	Ubiquitin-specific peptidase 18/ubiquitin-specific peptidase 41	1.52	1.78	2.11
AB044545	OAS3	2′-5′-oligoadenylate synthetase 3, 100kDa	1.44	1.57	2.10
BC010954	CXCL10	Chemokine (C-X-C motif) ligand 10	0.76	1.66	1.99
BC014896	USP18	Ubiquitin-specific peptidase 18	1.33	1.55	1.99
AL832618	IFI44L	Interferon-induced protein 44-like	0.58	1.31	1.95

We also assessed whether IFN-λ3 and IFN-α in combination could produce additive or synergistic effects on antiviral activity. In previous studies, additive antiviral activity against HCV was reported with the combination of IFN-λ1 and IFN-α [9, 10]. However, there have been no previous reports on the combined effects of IFN-λ3 and IFN-α. In this study, the focus was on IFN-λ3, because IFN-λ3 is suspected to be the key molecule, mediating the effect of SNPs in the IL-28B gene region on the anti-HCV response to IFN-α. As shown in Fig. 3 and Table S1, synergistic induction of anti-HCV activity occurred in both the OR6/C-5B and Huh7.5/JFH-1 HCV replicon systems. Synergy was demonstrated by the combination index values (Table S1).

Although it has been reported that the upregulated genes induced by IFN-λ are similar to those induced by IFN-α [9, 14–16], there have been no previous reports on

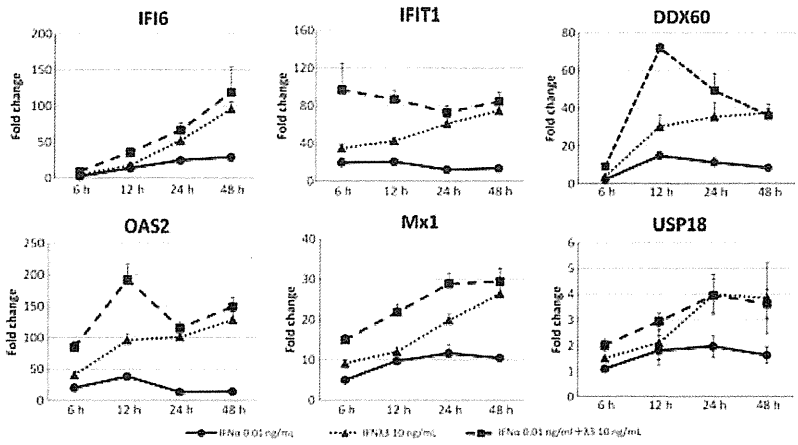

Fig. 5 Time course of ISG expression induced by 0.01 ng/mL IFN-α, 10 ng/mL IFN-λ3 or 0.01 ng/mL IFN-α plus 10 ng/mL IFN-λ3. Expression of the ISGs – IFI-6, IFIT1 (ISG56), DDX60, OAS2, Mx1 and USP18 – in OR6/ORN/C-5B/KE cells treated 6, 12, 24 and 48 h were determined by qRT-PCR. Results are presented as the relative fold induction. Symbols show the mean value of triplicate wells; error bars show the SD. *Solid lines* represent 0.01 ng/mL IFN-α alone, whereas *fine dashed lines* show 10 ng/mL IFN-λ3 alone, and *coarse dashed lines* show the combination of the 2 cytokines.

the genes induced by IFN-α and IFN-λ in combination. In cDNA microarray analysis, as demonstrated in Table 1, the most strongly upregulated genes induced by IFN-α/IFN-λ3 alone or in combination were almost identical, and most of them were ISGs. As no genes showed upregulation specific to IFN-λ3, we speculate that IFN-α and IFN-λ3 share a similar antiviral intracellular mechanism at the molecular level.

Unexpectedly in microarray analyses, synergistic upregulation of ISGs was not observed. In the same manner, TaqMan real-time RT-PCR analysis showed that the combination of IFN-α and IFN-λ3 did not upregulate ISGs synergistically (Fig. 5). In addition to cDNA microarray analysis, ISRE reporter assays were performed to determine the activation of components of the JAK-STAT pathway common to both type I and III IFNs. As shown in Fig. 4, each IFN upregulated ISRE activity, and the combination of IFN-λ3 and IFN-α did not synergistically enhance ISRE activity either.

Meanwhile, the peak time of the induction of ISG expression differs for IFN-α and IFN-λ1 [9, 17]: peak gene expression occurs earlier with IFN-α than with IFN-λ1. In our study, we confirmed that the peak induction of gene expression occurred later (24 h) and lasted longer (24–48 h) with IFN-λ3 than with IFN-α (12 h). Importantly, gene expression appeared early (12 h) and was prolonged (48 h) by the combination of both IFNs. Similarly to the peak time difference between IFN-α and IFN-λ3 seem for ISG expression, a time-dependent increase in ISRE activation was observed with the combination of both IFNs. While the precise mechanism remains to be clarified, differential regulation of the time-dependent induction of ISG gene expression could be one of the mechanisms underlying the synergistic antiviral effect. One of the molecules contributing to time-dependent ISG upregulation is the ISG known as ubiquitin-specific peptidase 18 (USP18), which has been reported to bind to IFNAR2 and inhibit the interaction of Jak1 with its receptor, thereby preventing IFN-α signalling while leaving IFN-λ signalling unaffected [18, 19]. Actually, expression of USP18 is specifically upregulated with IFN-λ3 in this study as shown in Fig. 5. If the ISGs upregulated by IFN-α are downregulated by USP18, it is plausible that the expression of genes induced by IFN-α decreases early, while expression of genes induced by IFN-λ lasts longer.

A number of clinical studies have confirmed that SNPs around the IL-28B gene are associated with the response to PEG-IFN and RBV therapy, and as previously indicated, various investigations have been performed to clarify the underlying mechanism. Specifically, increased IL-28B mRNA expression in PBMC [2, 3], high serum concentrations of IFN-λ1 (IL-29) [20], low expression of ISGs in the liver prior to IFN treatment [8, 21] and high upregulation of ISG expression by IFN treatment [8, 22] were found in subjects with IL-28B SNP genotypes associated with SVR (rs12979860 CC and rs8099917 TT). Although the functional role of IFN-λ3 still needs to be investigated more thoroughly, if IFN-λ3 expression change is the essential difference in determining the clinical treatment response to PEG-IFN and RBV therapy and if its expression is decreased in patients with the specific IL-28B genotype, which is associated with non-SVR, it is possible that exogenous administration of IFN-λ3 might improve IFN-α-induced viral clearance and that such treatment would be beneficial for patients with the IFN-resistant IL-28B genotype.

In present study, the OR6-cultured cells harboured the rs8099917 TT genotype, and recombinant IFN-λ3 (IL-

28B) protein used in the experiment was derived from cells with the rs8099917 TT genotype (data not shown). Therefore, the viral responses and/or cellular gene expression change in cells and/or proteins with different IL-28B genotypes *in vitro* should be determined in future studies.

In conclusion, we demonstrated that IFN-α and IFN-λ3 synergistically enhance anti-HCV activity *in vitro*. Although the ISGs upregulated by IFN-α and IFN-λ3 were similar, differences in time-dependent upregulation of these genes, especially prolonged ISGs expression by IFN-λ3, might contribute to their synergistic antiviral activity.

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CONFLICT OF INTEREST

Shinya Maekawa and Taisuke Inoue belong to a donation-funded department that is funded by MSD co. ltd.

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SUPPORTING INFORMATION

Additional Supporting Information may be found in the online version of this article:

Figure S1: IFN-α and IFN-λs inhibit HCV core protein secretion. JFH1-infected Huh7.5.1 cells were incubated with various concentrations of IFN-α and IFN-λ1, -λ2, -λ3. After 48 h of treatment, HCV core protein in the medium was measured. Symbols show the mean value of triplicate wells; error bars show the SD. *: $p < 0.05$ vs. control (IFN 0ng/ml).

Figure S2: The dimethylthiazol carboxymethoxyphenyl sulfophenyl tetrazolium assay was performed after OR6/ORN/C-5B/KE cells were cultured with various concentrations of (A) IFN-α, (B) IFN-λ1, (C) IFN-λ2, (D) IFN-λ3 and (E) combination of IFN-α and IFN-λ3 for 48 h. Symbols show the mean value of triplicate wells; error bars show the SD. *: $p < 0.05$ vs. control (IFN 0ng/ml).

Figure S3: The dimethylthiazol carboxymethoxyphenyl sulfophenyl tetrazolium assay was performed after Huh7.5.1/JFH-1 cells were cultured with various concentrations of (A) IFN-α, (B) IFN-λ1, (C) IFN-λ2, (D) IFN-λ3 and (E) combination of IFN-α and IFN-λ3 for 48 h. Symbols show the mean value of triplicate wells; error bars show the SD. *: $p < 0.05$ vs. control (IFN 0ng/ml).

Table S1: Combination index after 48hr stimulation by CalucSyn.

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Comprehensive Analysis for Viral Elements and Interleukin-28B Polymorphisms in Response to Pegylated Interferon Plus Ribavirin Therapy in Hepatitis C Virus 1B Infection

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To comprehensively characterize the contribution of virological factors as well as interleukin-28B (IL28B) single-nucleotide polymorphisms (SNPs) in determining treatment responses in pegylated-interferon plus ribavirin (Peg-IFN/RBV) therapy for chronic hepatitis C virus (HCV)-1b infection, we undertook a retrospective cohort analysis for the pretreatment dominant complete HCV open reading frame (ORF) amino-acid (aa) sequence study in 103 consecutive HCV-1b Japanese patients. The dominant HCV sequences classified by the response were subjected to systematic sliding-window comparison analysis to characterize response-specific viral sequences, along with IL28B SNP analyses (rs8099917). In each comparison of the patients between with and without rapid viral response (RVR), nonearly viral response (nEVR), sustained virological response (SVR), or relapse, the following regions were extracted as most significantly associated with the different responses respectively: nonstructural protein 5A (NS5A) aa.2224-2248 (P = 1.2E-07); core aa.70 (P = 4E-04); NS5A aa.2340-2382 (P = 7.0E-08); and NS5A aa.2360-2377 (P = 1.1E-05). Those NS5A regions nearly coincided with the interferon (IFN) sensitivity-determining region (NS5A aa.2209-2248) and the IFN/RBV resistance-determining region (NS5A aa.2339-2379). In a multivariate analysis, the IL28B SNP (odds ratio [OR] = 16.8; P = 0.009) and NS5A aa.2340-2382 (OR = 13.8; P = 0.0003) were extracted as the two most-significant independent variables contributing to the final outcome. *Conclusion:* In Peg-IFN/RBV therapy, polymorphisms in IL28B, NS5A aa.2224-2248, core aa.70, and, most important, NS5A aa.2340-2382 have a tremendous influence on treatment response in association with viral kinetics, resulting in significantly different outcomes in chronic HCV-1b infection. (HEPATOLOGY 2012;56:1611-1621)

Hepatitis C vrus (HCV) is a major cause of chronic liver disease (CLD) worldwide, causing CLD that may progress to hepatocellular carcinoma (HCC).[1] Treatment response of the conventional pegylated interferon (Peg-IFN) plus ribavirin (RBV) therapy is highly variable, and half of the patients cannot eradicate the virus (i.e., sustained virological response; SVR).[2] Recently, direct-acting

Abbreviations: aa, amino acid; AFP, alpha-fetoprotein; ALB, albumin; ALT, alanine aminotransferase; BMI, body mass index; cEVR, complete early viral response; cEVR-8w, HCV RNA <50 IU/mL at between weeks 5 and 8; cEVR-12w, HCV RNA <50 IU/mL at between weeks 9 and 12; CI, confidence interval; CLD, chronic liver disease; DAAs, direct-acting antiviral agents; ETR, end-of-treatment response; EVR, early viral response; Hb, hemoglobin; HCC, hepatocellular carcinoma; HCV, hepatitis C virus; IFN, interferon; IL28B, interleukin-28B; IRRDR, IFN/RBV resistance-determining region; ISDR, IFN sensitivity-determining region; nEVR, nonearly viral response; NS5A, nonstructural protein 5A; OR, odds ratio; ORF, open reading frame; PCR, polymerase chain reaction; Peg-IFN, pegylated IFN; PePHD, PKR-eIF2 phosphorylation homology domain; pEVR, partial early viral response; PKR-BD, PKR-binding domain; PLT, platelet count; RBV, ribavirin; RVR, rapid viral response; SNPs, single-nucleotide polymorphisms; SVR, sustained viral response; T-Cho, total cholesterol.

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antiviral agents (DAAs) have been under development, and telaprevir and boceprevir have now been included in HCV treatment regimens in the Unites States. However, it has gradually became learned that HCVs showing resistance to Peg-IFN/RBV therapy might demonstrate higher resistance to these new regimens of Peg-IFN/RBV plus DAAs.[3] In this background, it is urgent to clarify a comprehensive characterization of viral and host determinants for Peg-IFN/RBV therapy and to determine the most appropriate candidates for the new therapies.

In interferon (IFN)-based therapy, treatment response is influenced by multiple host and viral factors. Among the host factors, younger age, milder fibrosis stage, being nonobese,[4] being Asian or Caucasian rather than African,[5] and, recently, the interleukin-28B (IL28B) major allele type[6-8] are associated with favorable responses. Among the viral factors, low baseline viral load and genotype 2/3, rather than genotype 1/4, show favorable responses.[9] On the other hand, the contribution of other viral factors, such as polymorphisms in several restricted viral genetic regions, has long been debated in terms of their association with treatment responses. HCV genetic elements, including the IFN sensitivity-determining region (ISDR) in nonstructural protein 5A (NS5A),[10,11] PKR-binding domain (PKR-BD) in NS5A,[12,13] the V3 region in NS5A,[14] the IFN/RBV resistance-determining region (IRRDR) in NS5A,[15] the PKR-eIF2 phosphorylation homology domain (PePHD) of E2,[16] the C-terminal region of NS5A (G404S and E442G),[17] F415Y in NS5B,[18] polymerase motif in NS5B,[19] and amino acid (aa).70 and 91 in core,[20] have been investigated for their correlation with the clinical outcome of IFN-based therapy or RBV in genotype 1 infection. Complete open reading frame (ORF) analyses in Peg-IFN/RBV therapy also revealed the link between treatment response at day 28 or treatment outcome with viral diversities in several viral genomic regions in genotype 1 infection.[21,22] Importantly, most recent studies reported the strong contribution of core aa.70, ISDR, and IL28B polymorphisms in the response of Peg-IFN/RBV therapy in genotype 1b infection.[11,23]

Nevertheless, a comprehensive analysis of how these viral elements affect treatment response has not been presented clearly yet, especially along with IL28B single-nucleotide polymorphisms (SNPs). Moreover, inconsistent results that have been reported on for some of those regions made the association with the response obscure. Under these circumstances, the previous studies had limitations regarding the following points: (1) Viral regions selected for analysis were partial; (2) associations among different viral regions were not evaluated; (3) most studies investigated the associations only with the final SVR rate, although this is influenced by multiple factors, other than a simple virological response; (4) some studies have included patients with different racial backgrounds; and (5) most studies lacked analysis with IL28B polymorphisms.

To overcome these limitations, we have recently determined complete HCV ORF sequences of 88 patients receiving Peg-IFN/RBV, and confirmed that the NS5A-ISDR and core 70 were specifically extracted as regions most significantly correlated to rapid viral response (RVR) and nonearly viral response (nEVR), respectively.[24] In the present study, we undertook more comprehensive, detailed analysis to disclose the effect of HCV ORF on determining early viral response (EVR), final outcome, and relapse by extending the previous result through adding the information of IL28B polymorphisms in Japanese patients given Peg-IFN/RBV therapy for genotype 1b HCV.

Patients and Methods

Study Patients. We retrospectively analyzed consecutive patients with chronic HCV-1b infection treated with combination therapy of Peg-IFN/RBV at the Yamanashi University Hospital (Yamanashi, Japan) between December 2004 and July 2008. Eligible patients were 18-75 years of age, seronegative for hepatitis B surface antigen and antibodies against human immunodeficiency virus, and had an absolute neutrophil count $\geq 1{,}500/mm^3$, a normal hemoglobin (Hb) level, and available pretreatment serum sample conserved for HCV-sequence analysis. Patients were excluded if they had decompensated liver cirrhosis or HCC. Consequently, 103 patients were eligible for this study. In addition to those 103 patients, 30

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consecutive patients who received the standard length of Peg-IFN/RBV at the Yamanashi University Hospital from August 2008 to April 2011 and were meeting the above-mentioned criteria were also included in the study to perform uni- and multivariate analysis for SVR and relapse. The study was approved by the ethics committees of the University of Yamanashi, and the study protocol conformed to the ethical guidelines of the 2000 Declaration of Helsinki.

Doses and treatment periods were determined according to a standard treatment protocol for Japanese patients, established by a hepatitis study group of the Ministry of Health, Labor, and Welfare, Japan. Patients were treated with Peg-IFN-α-2b (1.5 μg/kg, once-weekly, subcutaneously) and RBV (600-800 mg daily, per os) for 48 weeks. When patients failed to achieve a 2-log reduction of HCV RNA at week 12 (nEVR), or failed to achieve HCV RNA clearance (HCV RNA, <50 IU/mL) at week 24 (null viral response), the therapy was discontinued if they did not desire to continue. For patients without viral clearance by week 13, the therapy period was extended up to 72 weeks if they agreed. For patients having achieved viral clearance (HCV RNA, <50 IU/mL) within 4 weeks (RVR), the therapy could be reduced to 24 weeks if they agreed.

Analytic Methods. The following patient characteristics were analyzed: age; sex; stage of fibrosis on liver biopsy; body mass index (BMI); alanine aminotransferase (ALT); Hb; gamma-glutamyl transpeptidase (γ-GTP); total cholesterol (T-Cho); albumin (ALB); platelet counts (PLTs); alpha-fetoprotein (AFP); serum HCV RNA; Peg-IFN dose; and RBV dose. Liver-biopsy specimens were evaluated blindly by an independent interpreter. HCV RNA was determined by polymerase chain reaction (PCR) (Amplicor HCV RNA kit, version 2.0; Roche Diagnostics Corp., Indianapolis, IN).

Viral Response. Patients were subdivided into four groups according to the initial response at week 12. Each group was defined as follows: RVR (<50 IU/mL at week 4); complete early viral response (cEVR; HCV RNA <50 IU/mL at between weeks 5 and 12); partial EVR (pEVR; HCV RNA ≥2-log reduction, but still detectable [≥50 IU/mL] at week 12); and nEVR (HCV RNA <2-log drop at week 12). SVR was defined as undetectable HCV RNA 24 weeks after completion of therapy. Viral relapse after the achievement of end-of-treatment response (ETR) were also evaluated. In some analysis, cEVR was further divided into two groups of cEVR-8w (HCV RNA <50 IU/mL at between weeks 5 and 8) and cEVR-12w (HCV RNA <50 IU/mL at between weeks 9 and 12).

Complete HCV ORF Sequencing. Extraction of RNA, complementary DNA synthesis, and nested PCR were performed using patient serum collected before starting therapy, as described previously.[25] The full-length HCV genome was amplified by nested PCR with 20 partially overlapping primer sets. Both strands of PCR products were cycle-sequenced with the BigDye Terminator v3.1 Cycle Sequencing Kit (Applied Biosystems, Tokyo, Japan), according to the manufacturer's instructions, using an M13 forward as well as reverse primers. Products were sequenced by an automated DNA sequencer (3130 series; Applied Biosystems). Nucleotide and predicted aa sequences of 20 HCV genomic fragments were determined and assembled using vector NTI software (Invitrogen, Tokyo, Japan).

Sliding-Window Analysis. A sliding-window analysis was introduced to search for HCV polypeptide regions related to treatment response. Briefly, the total number of aa substitutions, compared to the consensus sequence, within a given number of consecutive aas (window) was counted at each aa position in each HCV sequence. The distribution of aa substitutions in the HCV ORF was scanned, applying these windows from aa.1 to aa.3010. The substitution numbers in each window and the treatment response was compared statistically between the two groups, showing different treatment response by Mann-Whitney's U test for each aa window. In each comparison, the length of peptide window was changed from 1 to 100 aas to search for those regions. Consequently, approximately 300,000 windows (100 width × 3,010 aas) were analyzed for each HCV aa sequence. To visualize the result, windows showing significantly low P values were colored in red and nonsignificant P values were colored in green to generate a "heat map" appearance using Microsoft Excel (Microsoft Corp., Redmond, WA), whereas the window with the lowest P value was colored in white to be distinguished clearly.

IL28B SNP Analysis. Human genomic DNA was extracted from peripheral blood using a blood DNA extraction kit (QIAGEN, Tokyo, Japan), according to the manufacturer's protocol. The allele typing of each DNA sample was performed by real-time PCR (model 7500; Applied Biosystems) using fluorescein-amidite–labeled SNP primer for the locus rs8099917 (purchased from Applied Biosystems).

Statistical Analysis. Statistical differences in parameters, including all available patient demographic, biochemical, hematological, and virological data, was determined between patients in various groups by the Student t test or Mann-Whitney's U test for numerical variables and Fisher's exact probability test for categorical variables.

Table 1. Baseline Characteristics of 103 Patients and SVR Rate

Variables	Initial 103 Patients
Age, years	56 (31-70)
Gender, male (%)	64 (62)
Fibrosis, F2-F4 (%)	46 (44)
HCV RNA, kIU/mL	1,500 (28-8,392)
BMI	22.7 (17.5-31.7)
ALB, g/dL)	4.1 (3.0-4.9)
γ-GTP, IU/mL	43 (11-289)
ALT, IU/mL	68 (20-413)
T-Cho, mg/dL	165 (104-240)
WBCs, per μL	4,450 (2,520-7,850)
Hb, g/dL	14.2 (11.2-17.9)
PLT, $\times 10^4/\mu L$	14.5 (6.5-27.3)
AFP, ng/mL	5.8 (0.7-468.4)
IL28B TT (%)	65 (73)*
Peg-IFN dose (%)	89 (43-147)
RBV dose (%)	98 (49-133)
SVR rate (n, %)	
All (n = 103)	55 (53)
Standard therapy (n = 76)	
RVR (n = 10)	10 (100)
cEVR (n = 35)	28 (80)
pEVR (n = 15)	3 (20)
nEVR (n = 16)	0 (0)
Extended therapy (n = 27)	
RVR (n = 0)	–
cEVR (n = 5)	3 (60)
pEVR (n = 18)	11 (61)
nEVR (n = 4)	0 (0)

Abbreviation: WBCs, white blood cells.
*n = 89.

Variables with $P < 0.05$ in univariate analysis were entered into multiple logistic regression analysis to identify significant independent factors with the odds ratios (ORs) as well as 95% confidence intervals (CIs). All P values of <0.05 by the two-tailed test were considered significant.

Results

Patient Characteristics. Clinical background factors of the 103 patients are shown in Table 1. Responses at 12 weeks were closely related to the final outcome of therapy. In the standard therapy up to 48 weeks, the SVR rate was 100%, 80%, 20%, and 0% for the RVR, the cEVR, the pEVR, and the nEVR, respectively. Among 103 patients, 27 patients from three groups received extended therapy (5 from cEVR-12w, 18 from pEVR, and 4 from nEVR). Although improvement of SVR was observed in the pEVR (from 20% to 61%), there was no improvement in cEVR or nEVR.

Clinical background factors of the 30 patients who were additionally included for uni- and multivariate analysis for SVR and relapse receiving the standard period of Peg-IFN/RBV therapy are also shown (Supporting Table 1).

IL28B SNPs and Their Relationship to Viral Diversity. To evaluate the contribution of the IL28B polymorphism in the 103-patient study group, we investigated the rs8099917 SNPs in 89 patients available for analysis. The polymorphism was closely related to the viral response at week 12 (Table 2). To clarify the relationship between viral diversity and IL28B SNPs, we compared viral sequences between the major allele groups showing favorable initial response (TT) and the minor allele groups showing poor initial responses (TG or GG). IL28B SNP was significantly correlated with the aa residue at core aa.70 in full HCV ORF analysis ($P = 3.4E-06$); non-arginine at core aa.70 was closely related to minor IL28B alleles and vice versa (Supporting Fig. 1).

HCV Sequences Related to RVR and nEVR. To characterize the HCV sequences related to RVR and nEVR, we determined the full dominant HCV ORF sequences by direct sequencing and searched for polymorphic aa positions specifically related to the different responses. Though aa.2240 was extracted as the most-different single position between the RVR and the remainder (data not shown), successive sliding-window analysis revealed that aa.2224 to aa.2248 of the NS5A region, being completely included in the ISDR (aa.2209 to aa.2248), was the region most significantly related to the RVR ($P = 0.00037$; Fig. 1A). On the other hand, when the nEVR and the remainder were compared, core aa.70 was extracted as the most-significant single aa position discriminating the two groups ($P = 7.0E-8$; Fig. 1B). In this comparison of the nEVR versus the remainder, a sliding-window analysis also extracted regions around aa.70 to be the most significantly different (data not shown).

HCV Sequences Related to Final Outcome. We also compared the viral sequence between SVR and non-SVR patients. In comparing complete HCV ORFs, we confined this analysis to HCV sequences obtained from the standard therapy (n = 76) to exclude the influence of therapy duration. In the analysis of each single aa, various differences were observed

Table 2. IL28B SNPs at rs8099917 and the Initial Viral Responses*

	RVR (%) (n = 8)	cEVR-8w (%) (n = 17)	cEVR-12w (%) (n = 15)	pEVR (%) (n = 31)	nEVR (%) (n = 18)
TT	8 (100)	16 (94)	13 (87)	24 (77)	4 (22)
TG	0 (0)	1 (6)	1 (7)	7 (23)	12 (67)
GG	0 (0)	0 (0)	1 (7)	0 (0)	2 (11)

*n = 89.

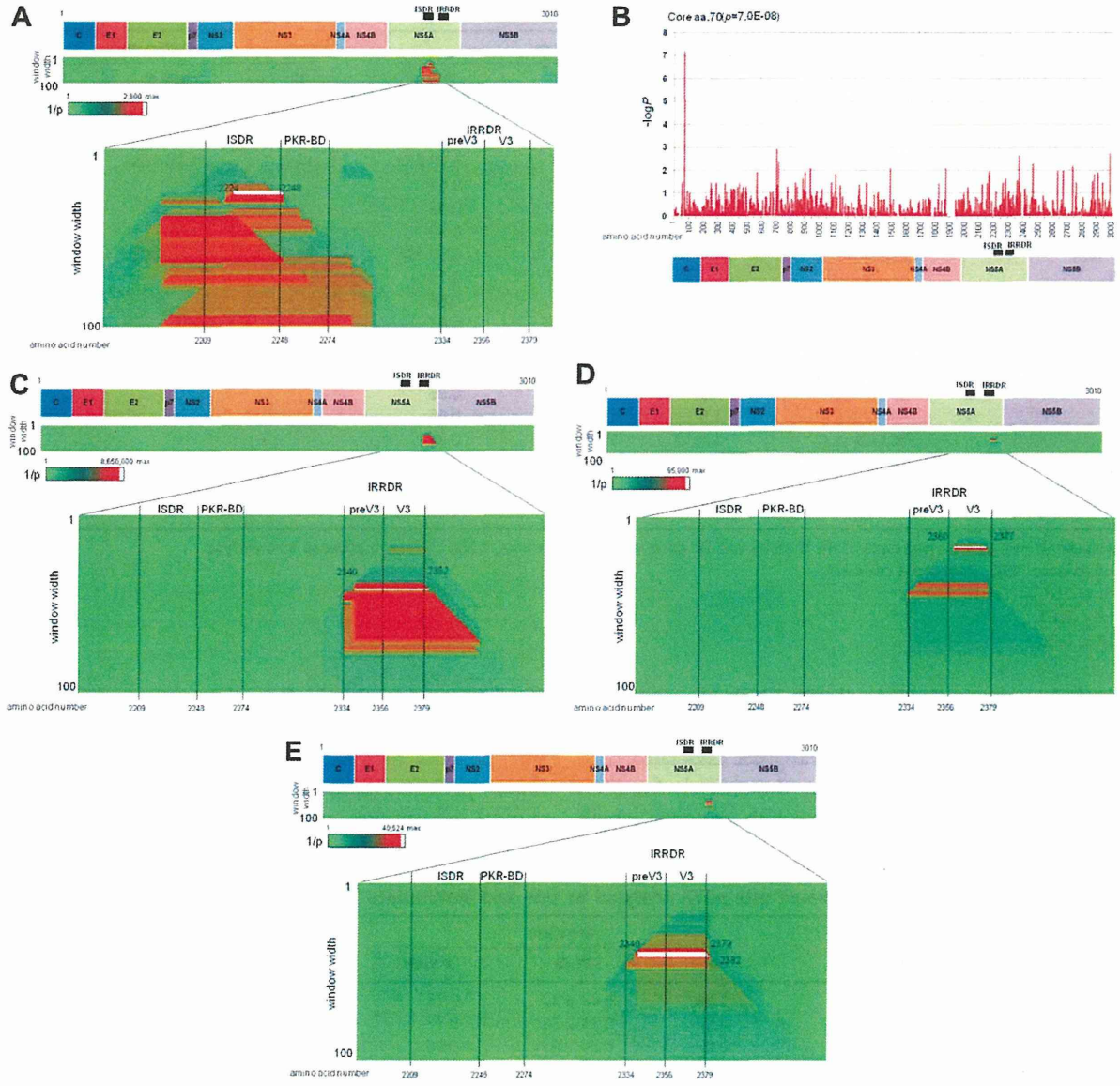

Fig. 1. The contribution of viral sequences and IL28B SNPs in the treatment response to Peg-IFN/RBV was studied. (A) Sliding-window analysis for RVR versus the remainder (n = 103). (B) Single aa analysis for nEVR versus the remainder (n = 103). (C) Sliding-window analysis for SVR versus non-SVR (n = 76). (D) Sliding-window analysis for relapsers versus nonrelapsers among ETR (n = 57). (E) Sliding-window analysis for SVR versus non-SVR in IL28B TT patients with standard therapy (n = 47).

in the HCV ORF, including core aa.70 and NS5B (data not shown). However, a sliding-window analysis disclosed that NS5A region aa.2340 to aa.2382, the region almost coinciding with IRRDR, was extracted as the most clearly related to the final outcome (P = 1.2E-07; Fig. 1C).

HCV Sequences Related to Relapse. To identify the viral regions related to relapse, we compared SVR patients and non-SVR patients among 57 patients with standard therapy achieving ETR (40 nonrelapsers and 17 relapsers). A sliding-window analysis disclosed that the NS5A region aa.2360 to aa.2377, the region almost coinciding with the V3 region in the IRRDR, could be extracted as the most strongly related to relapse (P = 1.1E-05; Fig. 1D).

Uni- and Multivariate Analyses. We performed further analyses to extract the factors associated with RVR, nEVR, SVR, and relapse by univariate, as well as multivariate, analyses. For achieving RVR, ISDR aa.2224-2248 and HCV-RNA were extracted as independent variables (Table 3). Because all the RVR patients possessed IL28B TT alleles and OR

Table 3. Factors Associated With RVR Analyzed by Uni- and Multivariate Logistic Regression Analysis*

		Univariate			Multivariate		
		OR	95% CI	*P* Value	OR	95% CI	*P* Value
Age, years	60≤	0.7	0.18-2.59	0.57			
Gender	Male	1.5	0.36-6.07	0.59			
ISDR 2224-2248	1≤	24.6	4.70-129	8.5E-07†	14.7	1.10-198	0.04‡
IRRDR 2340-2382	4≤	6.2	0.76-51.1	0.06			
Core 70	Arg	0.7	0.18-3.07	0.68			
Fibrosis	<2	3.6	0.72-17.8	0.10			
HCV RNA	<600 k/UI/mL	74.7	8.55-653	8.3E-10†	51.2	3.97-662	0.003†
BMI	<23	1.3	0.34-4.87	0.71			
ALB	4.1 g/dL≤	1.1	0.30-4.28	0.85			
γ-GTP	50 IU/mL≤	0.9	0.24-3.49	0.91			
ALT	60 IU/mL<	0.9	0.25-3.59	0.94			
T-Cho	<170 mg/dL	1.2	0.33-4.67	0.76			
WBC	4,700/μL≤	1.9	0.47-7.89	0.36			
Hb	14 g/dL≤	1.5	0.37-6.35	0.55			
PLT	150,000/μL≤	1.8	0.48-6.88	0.37			
AFP	10 ng/mL≤	0.3	0.03-2.37	0.22			
Peg-IFN dose (%)	80≤	1.3	0.33-5.55	0.68			
RBV dose (%)	80≤	3.0	0.79-11.4	0.09			

Because all RVR patients possessed IL28B TT alleles and OR calculation was impossible, IL28B SNPs were secluded from analysis.
Abbreviation: WBC, white blood cell count.
*n = 103.
†$P < 0.01$.
‡$P < 0.05$.

calculation was impossible, IL28B SNPs were excluded from the analysis. Likewise, core aa.70 and IL28B were extracted as independent variables associated with nEVR (Table 4). In performing the analysis for SVR and relapse, we excluded patients with extended length of therapy to standardize the treatment periods. Because this restriction reduced the number of available patients for the analysis, we included 30 additional patients (Supporting Table 1) with available clinical information, including HCV core, NS5A, and

Table 4. Factors Associated with nEVR Analyzed by Uni- and Multivariate Logistic Regression Analysis*

		Univariate			Multivariate		
		OR	95% CI	*P* Value	OR	95% CI	*P* Value
Age, years	60≤	1.18	0.42-3.30	0.75			
Gender	Male	0.86	0.31-2.38	0.77			
ISDR 2224-2248	1≤	0.97	0.29-3.28	0.96			
IRRDR 2340-2382	4≤	0.25	0.09-0.69	5.0E-03‡	0.21	0.03-1.33	0.1
Core 70	Arg	0.03	0.01-0.16	2.0E-08‡	0.04	0.00-0.04	0.008‡
IL28B†	Major allele	0.05	0.01-0.17	5.4E-08‡	0.1	0.01-0.57	0.011§
Fibrosis	<2	0.28	0.08-1.0	0.04§	0.5	0.03-0.57	0.55
HCV RNA	<600 k/UI/mL	0.19	0.02-1.5	0.08			
BMI	<23	0.97	0.36-2.58	0.95			
ALB	4.1 g/dL≤	0.69	0.26-1.85	0.46			
γ-GTP	50 IU/mL≤	1.95	0.73-5.22	0.18			
ALT	60 IU/mL<	0.38	0.14-1.03	0.05			
T-Cho	<170 mg/dL	0.34	0.11-1.03	0.06			
WBC	4,700/μL≤	0.64	0.23-1.76	0.38			
Hb	14 g/dL≤	0.82	0.29-2.26	0.70			
PLT	150,000/μL≤	0.42	0.15-1.19	0.10			
AFP	10 ng/mL≤	5.12	1.82-14.4	0.001‡	3.5	0.52-23.2	0.20
Peg-IFN dose (%)	80≤	0.37	0.14-1.01	0.048§	0.9	0.13-5.93	0.89
RBV dose (%)	80≤	0.38	0.12-1.23	0.10			

Abbreviation: WBC, white blood cell count.
*n = 103.
†n = 89.
‡$P < 0.01$.
§$P < 0.05$.

Table 5. Factors Associated With SVR Analyzed by Uni- and Multivariate Logistic Regression Analysis*

		Univariate			Multivariate		
		OR	95% CI	*P* Value	OR	95% CI	*P* Value
Age, years	60≤	0.8	0.34-1.78	0.55			
Gender	Male	1.4	0.61-3.22	0.43			
ISDR 2224-2248	1≤	6.3	1.98-20.26	0.001†	13.4	1.86-96.5	0.010†
IRRDR 2340-2382	4≤	11.1	4.07-30.54	4.08E-07‡	13.8	3.31-57.4	0.0003‡
Core 70	Arg	3.2	1.37-7.59	0.007‡	2.2	0.43-11.7	0.34
IL28B	Major allele	9.6	2.92-31.34	0.00003‡	16.8	2.04-139	0.009‡
Fibrosis	<2	3.1	1.33-7.23	0.008‡	1.4	0.31-6.64	0.65
HCV RNA	<600 k/UI/mL	3.5	1.39-9.02	0.007‡	3.5	0.72-17.3	0.12
BMI	<23	1.0	0.44-2.20	0.97			
ALB	4.1 g/dL≤	0.9	0.39-1.96	0.75			
γ-GTP	<50 IU/mL	2.6	1.13-5.88	0.02†	3.5	0.90-13.47	0.07
ALT	≤60 IU/mL	0.8	0.35-1.77	0.57			
T-Cho	<170 mg/dL	1.7	0.71-3.94	0.24			
WBC	<4,700/μL	0.8	0.36-1.87	0.64			
Hb	<14 g/dL	0.9	0.35-2.13	0.75			
PLT	150,000/μL≤	2.6	1.06-6.56	0.03†	3.5	0.71-16.8	0.20
AFP	<10 ng/mL	3.7	1.49-9.29	0.004‡	3.4	0.54-21.2	0.20
Peg-IFN dose (%)	80≤	2.2	0.96-5.13	0.06			
RBV dose (%)	80≤	0.8	0.37-1.92	0.68			

Abbreviation: WBC, white blood cell count.
*n = 97.
†$P < 0.05$.
‡$P < 0.01$.

IL28B SNPs. Those 30 patients were consecutively introduced the Peg-IFN/RBV therapy at Yamanashi University Hospital in succession to the initial 103 patients. As a result, 97 patients were available for SVR analysis, and 78 patients were available for relapse analysis. ISDR aa.2224-2248, IRRDR aa.2340-2382, and IL28B SNPs were extracted as the independent variables affecting SVR (Table 5). On the other hand, IRRDR-V3 aa.2360-2377 was extracted as an independent factor for relapse (Supporting Table 2).

Contribution of IL28B SNPs and NS5A aa.2340-2382 in Determining Treatment Response. Because multivariate analysis finally extracted IL28B SNPs and IRRDR aa.2340-2382 as the two most-significant variables determining final outcome, the correlation of IL28B SNPs and IRRDR aa.2340-2382 in association with final outcome was further investigated. Alignment of IRRDR aa.2340-2382 in association with SVR was demonstrated (Fig. 2). By this analysis, it was evident that three or more mutations in IRRDR aa.2340-2382 were significantly associated with SVR. Last, to disclose the viral sequence contribution in the determination of final outcome in IL28B TT haplotype patients with the standard therapy (n = 47), sliding-window analysis was performed (Fig. 1E). As demonstrated here, NS5A IRRDR aa.2340-2379 (~2382) was finally extracted as the most-significant viral region contributing to final outcome ($P = 2.47E-05$).

The contribution of these three viral regions in the phase-specific treatment responses is schematically illustrated (Fig. 3).

Discussion

In this study, we determined 103 complete HCV ORF sequences in consecutive Japanese patients, infected with genotype 1b HCV and given PEG-IFN/RBV therapy, and systematically searched and investigated the contribution of viral regions associated with the phase-specific treatment responses with IL28B SNP haplotypes. To our knowledge, this study is most comprehensive in the following aspects: (1) complete HCV ORF studied with the largest analyzed number of patients; (2) analyzed according to viral kinetics closely related to outcome; (3) unified to a single genotype (1b); (4) unified background of patients; (5) introduction of a sliding-window method to screen the responsible viral regions systematically; and (6) analysis of IL28B SNPs.

In a recent randomized, controlled study of Peg-IFN/RBV combination therapy, the status of patients according to response to Peg-IFN/RBV therapy at 12 weeks showed a marked correlation with final outcome, and viral response at week 12 has been considered as a useful predictor in early-response–guided therapy.[26] In agreement with the previous study, virological responses to Peg-IFN/RBV at week 12 had a

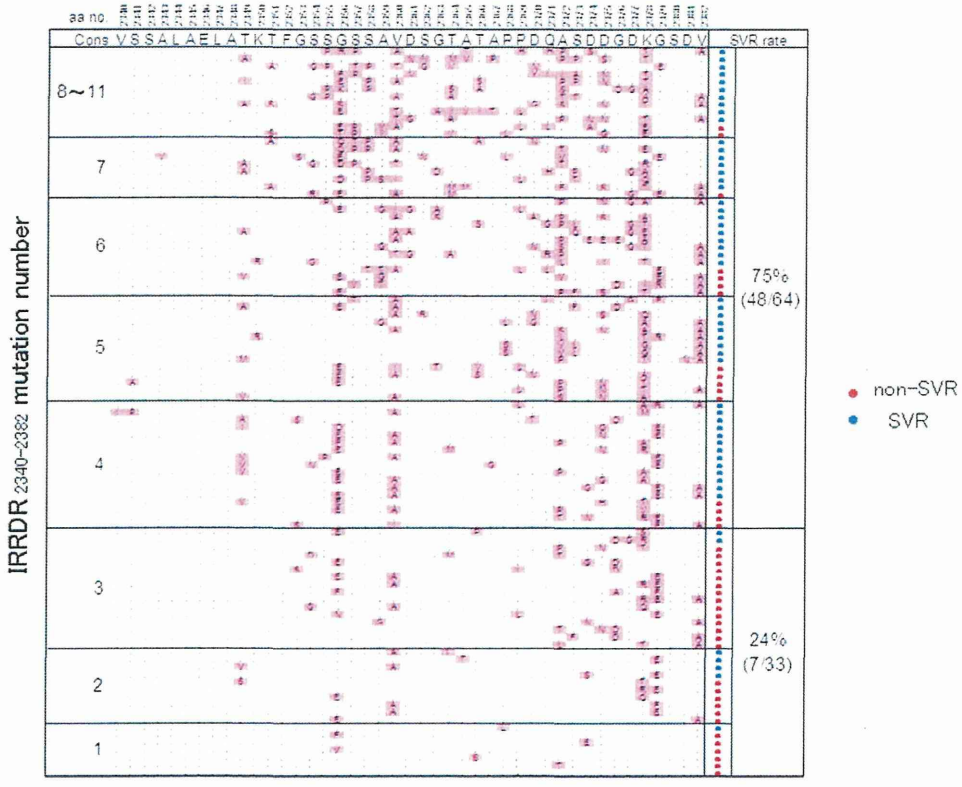

Fig. 2. Alignment of NS5A region around IRRDR aa.2340-2382, along with SVR.

distinct correlation with the final outcomes in our study group (SVR rate: 100%, 80%, 20%, and 0% for RVR, cEVR, pEVR, and nEVR in standard therapy). These results demonstrated that classification by viral response at week 12 provides distinct groups with different characteristics.

We first tried to identify regions of the HCV ORF by showing a distinct linkage to RVR and nEVR. We found that HCV substitutions around the ISDR (aa.2224-2248 in RVR) were most significantly correlated with early viral clearance in Peg-IFN/RBV therapy. In contrast, core aa.70 substitution was most significantly correlated with nEVR, demonstrating the association with treatment resistance. According to the results shown here, early HCV dynamics in Peg-IFN/RBV therapy are significantly regulated by the specific viral sequences in core and NS5A (Fig. 1A,B).

Next, we determined that HCV genomic region correlated with SVR of patients with standard therapy. We excluded patients with extended therapy to unify treatment duration. Considering the length of treatment, we first suspected that multiple factors might affect the final outcome of 48 weeks of standard therapy, and that determining viral regions reflecting pure

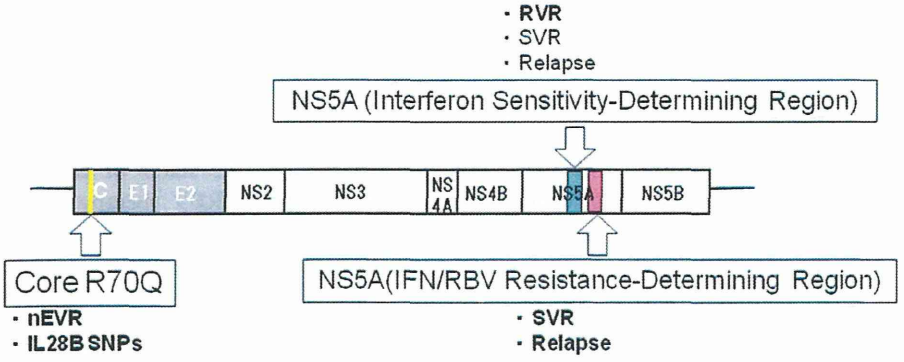

Fig. 3. Roles of three HCV-1b viral regions in the determination of time-dependent treatment response to Peg-IFN/RBV therapy.

biological response would be difficult. Contrary to our prediction, a region almost identical to the IRRDR (aa.2340-2382) was extracted by systematic sliding analysis as correlated with outcome, with a significantly high *P* value, demonstrating the remarkable influence of the IRRDR aa.2340-2382 in determining final outcome (Fig. 1C). Importantly, in addition to final outcome, when relapser and nonrelapser in the ETR were compared, aa.2360-2377, the region almost coinciding with the V3 region of the IRRDR, was extracted as the region discriminating these two groups (Fig. 1D).

In the analysis of IL28B SNPs (rs8099917), we observed a significant correlation between IL28B SNP and viral dynamics at week 12; patients with minor/minor or minor/major alleles showed significantly poor responses, as demonstrated in Table 2. On the other hand, because poor response was significantly associated with the substitution of the core aa.70 (as shown in Fig. 1B) in our study, we next tried to unveil the correlation between HCV ORF and IL28B SNPs. The significant link with the single core aa.70 substitution was observed through searching for the complete HCV ORFs (Supporting Fig. 1). The result coincides with recent studies[27-29] and, moreover, confirms that this single spot is extraordinarily linked to the initial poor response among the complete 3,010 HCV aa residues. Though the underlying mechanism for the association of IL28B and core aa.70 is unclear, the association would be a reflection of an interaction between the IL28B SNPs and HCV sequences in the development of chronic HCV infection, as discussed by Kurosaki et al.[29] Namely, it is possible that HCV sequences within the patient might have been selected during the course of chronic infection, depending on the IL28B SNPs, by selective pressures of unknown mechanism.

By multivariate analysis, IL28B SNP, IRRDR aa.2340-2382, and ISDR aa.2224-2248 were extracted as independent variables related to final outcome in patients with standard length of therapy with the inclusion of an additional 30 patients (Table 5). Among these, IL28B SNPs and IRRDR aa.2340-2382 were the two most-significant variables determining final outcome. Moreover, NS5A IRRDR aa.2340-2379 (~2382) was the most-significant viral region contributing to final outcome in patients with IL28B TT haplotype (P = 2.47E-05), demonstrating that combined information of the IL28B and IRRDR is significantly important in predicting viral kinetics and treatment outcome (Fig. 1D).

Most of the viral genomic regions identified in this study have already been reported on in previous, independent studies. However, the importance of our study is shown in the result that these specific viral regions of core, ISDR, and IRRDR were extracted all at once through systematic full HCV ORF sequence screening. What is unique in our study is the introduction of the sliding-window analysis; through this analysis, we could effectively confine viral regions of ISDR and IRRDR that were not identified in other previous HCV ORF studies.[21,22] Furthermore, our study also disclosed that the importance of these viral regions was different according to each treatment-phase; RVR, nEVR, SVR, and relapse were mostly related to the ISDR, core aa.70, the IRRDR, and IRRDR, respectively. The ISDR was the first region identified as being related to SVR in the era of IFN monotherapy in Japanese patients, such that multiple mutations in the ISDR were associated with favorable IFN responses.[10,30] The contribution of the core region in treatment response in IFN/RBV therapy was first reported on by Akuta et al., in that the polymorphisms of core aa.70 and 91 were closely related to final outcome.[20] The further significance of core polymorphism was reported on in hepatocarcinogenesis as well.[31,32] Our analysis also confirmed the recent studies reporting on the close correlation between viral core and IL28B SNPs.[11,29,32] The present finding that the core aa.70 is correlated with nEVR independently of IL28B seems to reflect the recent report that core aa.70 is an independent determinant of poor response to the triple therapy of Peg-IFN/RBV and telaprevir in patients with the IL28B minor allele.[27] On the other hand, the IRRDR was originally reported on by El-Shamy et al. as being related to the result of Peg-IFN/RBV therapy.[15] Importantly, our study revealed that final SVR and relapse were significantly correlated with mutations around the IRRDR. The result indicates its significant role in late-phase viral responses in Peg-IFN/RBV therapy.

Core is a main-component protein of viral nucleocapsid, and it has recently been found that the core located on the surface of lipid droplets associates with NS5A to facilitate virion formation.[33] HCV-JFH1 with core R70Q/H and L91M was reported to impair virion formation resulting in the accumulation of intracellular core protein, which causes endoplasmic reticulum stress leading to IFN resistance through suppressor of cytokine signaling 3 up-regulation induced by IL-6.[34] NS5A is a phosphoprotein and is considered to play a pivotal role both in viral replication and virion production, depending on its phosphorylation state.[35-37] Mutations in centrally located serine residues required for NS5A hyperphosphorylation as well as in

its adjacently located ISDR work as adaptive mutations in the HCV replicon, possibly through decreasing the hyperphosphorylated form of NS5A,[37-40] which seems to control HCV replication. The conservation of c-terminal serine residual cluster of NS5A, downstream to IRRDR, is required for NS5A basal phosphorylation, interaction with the core protein on the lipid droplet, and thus virion formation.[41,42] Taken together, it can be speculated that the structural changes in core and NS5A protein can coordinately modify HCV replication, especially through virion formation around lipid droplets. However, the precise mechanism through which these modulations of viral proteins lead to the different treatment response should be further investigated.

In conclusion, we have found that polymorphic viral sequences in core aa.70, NS5A-ISDR aa.2224-2248, and NS5A-IRRDR aa.2340-2382 in genotype 1b HCV infection are correlated significantly with the treatment phase-specific viral responses to Peg-IFN/RBV therapy. In addition, these viral responses were also significantly correlated with the polymorphism in IL28B SNP, and this polymorphism was significantly correlated with the polymorphism in the core. More important, combined information of IL28B and IRRDR aa.2340-2382 is significantly important in predicting viral kinetics and treatment outcome. We consider that our comprehensive study provides a new basis for introducing Peg-IFN/RBV therapy as well as a new generation of anti-HCV therapies.

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